Requirements for Third Party Liability -- Payment of Claims

Providers of medical services have the primary responsibility for assuring that third-party resources are applied to the cost-of-care before billing Medicaid. Except as provided below, a provider who submits a claim for a recipient who has a third-party resource must include with the claim an Explanation of Benefits (EOB) from each third-party resource known. For each third-party resource, the provider must indicate on the claim the amount of payment received. If payment was not available from a third-party resource, the provider must verify that the provider attempted to collect payment by attaching an EOB or other documentation showing that payment was actually denied by the third-party resource.

DMA will pay-and-chase claims for prenatal care and preventive pediatric services, including EPSDT. The state has received a waiver authorizing DMA to pay-and-chase claims for prescription drugs, transportation and accommodation, and personal care services.

Providers are required to bill liable third parties when services are provided to an individual on whose behalf child support enforcement is being carried out by the Title IV-D agency.

The current threshold for trauma claims is $250 per individual claim and does not include accumulated billings. For pay and chase categories, the MMIS system generates a bill to a third-party resource if the combined charges for all recipients to that third-party equal or exceed $50. There is no time limit on the accumulation of outstanding charges.

For casualty recoveries, the Department will comply with Section 1902 (a) (25) (B) of the Social Security Act and use the following factors and guidelines in determining whether to pursue recovery of benefit, after deduction of the Department's proportionate share of attorney's fees and costs, from a liable party.

1. Ascertain the amount of Medicaid lien and the amount of the gross settlement.

2. Determine whether the Medicaid lien plus attorney's fees and costs will exhaust or exceed the settlement funds.

3. If the answer to 2 is Yes, and if the Department:

   a. is informed the client will not pursue the claim; or

   b. cannot handle the case, once it is tendered to the Department by the client or the client's attorney to pursue on behalf of the client; or

   c. has made reasonable effort to ascertain the client's intention regarding the claim, but could not obtain a response; then

   the Department shall follow procedures stated in 4, below.

4. The Department shall consider the cost effectiveness principle in determining the estimated net recovery amount to be pursued, based on the likelihood of collections. Net recovery amount is

defined as that amount of recovered dollars to apply to Medicaid costs. In determining the net recovery amount, the following factors will be considered:

a. Settlement as may be affected by insurance coverage or other factors relating to the liable party;

b. Factual and legal issues of liability as may exist between the client and liable party;

c. Problems of proof faced in obtaining the award or settlement; and

d. The estimated attorney's fee and costs required for the Department to pursue the claim.

5 After considering the above factors, the Department may pursue a lesser recovery amount to the extent that the Department determines it to be cost effective to do so.